

CONNECTICUT

**DEPARTMENT OF MENTAL HEALTH
AND ADDICTION SERVICES**



**2012 REPORT ON STATEWIDE
PRIORITY SERVICES**

July 15, 2013

Introduction

Once every two years, the Department of Mental Health and Addiction Services (DMHAS) conducts a priority setting process that is meant to engage and draw upon the existing and extensive planning, advisory, and advocacy structures across the state. Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) form the basis of the regional priority setting process, facilitating grassroots input and independent viewpoints. In this role, the RMHBs and RACs promote interaction across a broad spectrum of stakeholders to:

- Determine unmet behavioral health needs and identify emerging issues
- Gain broad stakeholder input on service priorities, needs and solutions
- Foster ongoing dialogue regarding identified unmet needs in the regions

The 2012 Priority Setting Process is the sixth since the initiation of this coordinated planning process in 2002. In the intervening years (odd numbered years), RMHBs and RACs provide “updates” informing DMHAS of progress made in addressing the identified unmet needs in their regions and alerting the department to any emerging issues. In conducting these regional assessments, the RMHBs and RACs utilize DMHAS service data, local needs assessments, and other planning documents to reach the conclusions found in their regional priority reports. Through various assessment methods, RMHBs and RACs collect information on: 1) root causes of identified problems and unmet needs; 2) solutions and resources that may be required, including those which may be low or no cost; 3) gaps and barriers to implementing proposed solutions; and 4) needed cross-system collaborations.

The purpose of the 2012 Priority Setting Process was to produce one integrated, relevant planning document that would inform the development of Connecticut’s Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant applications, assist in the department’s development of a biennial (state fiscal years 2014 and 2015) budget, and reduce duplication of effort across RMHBs and RACs. Each region presented its findings to DMHAS staff and developed individual regional priority reports. In developing the *2012 Statewide Priority Service Report* (Priority Report), DMHAS reviewed all regional surveys and reports. As such the Priority Report is a reflection of common themes found across regions.

The Statewide Priority Report, which follows, is shared and discussed with the Adult Behavioral Health Planning Council, the Mental Health and Addiction Services State Board and the Commissioner’s Executive Group. Individual Regional priority reports can be found on the DMHAS website at:

<http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=451050>

The 2012 Priority Report is a summary of results from each regional report and is based upon the following assessment activities:

Treatment Provider Survey: Web-based survey administered to all DMHAS-operated and funded entities. Only one survey per provider agency was allowed and there was a 75% response rate statewide. Most of those provider agencies not responding were single service (e.g., housing) or smaller provider agencies. This was the third time the provider questionnaire was administered and the second time using the web-based application Survey Monkey. The questionnaire contained three sections: 1) perceived service availability from a list of clinical and support services; 2) a list of barriers that hinder access to or continuation of services; and 3) wait times for clinical services. Additionally, respondents could enter comments in the service availability and barriers sections. The survey had separate sections for mental health and addiction services.

Prevention Community Readiness Survey (CRS): In 2012, the CRS was administered for the third time and was targeted towards the needs of community prevention services. The survey was emailed to a wide range of prevention professionals and other stakeholders in all RAC communities and included a number of questions on perceived needs and resources in local communities.

Qualitative Methods: These consisted of focus groups held regionally by the RMHBs and RACs with key informants including consumers, family members, providers and referral organizations (such as town social workers, police, etc.). In some regions, the focus groups were held with targeted stakeholders such as young adults. Also RMHBs drew from their ongoing service assessments such as program evaluations and Catchment Area Council feedback. RACs drew upon their longstanding relationships with schools, law enforcement, human services organizations and other community stakeholders for their service assessments. Some regions conducted personal interviews with select stakeholders to better understand identified needs.

Additionally, the Priority Report includes findings from three focus groups held with community general hospital emergency department (ED) staff. The focus groups were conducted as part of the Office of Health Care Access (OHCA) Facility Plan process and were jointly facilitated by the Acute Care and Behavioral Health Subcommittees. The complete focus group findings and recommendations can be found at http://www.ct.gov/dph/lib/dph/ohca/publications/2012/ohcastatewide_facilities_and_services.pdf

Other: Local sources of need identification including the United Way assessments, municipal strategic planning projects and other planning activities were incorporated, where relevant, to the DMHAS population by the RACs and RMHBs.

In 2012, DMHAS contracted with the University of Connecticut Health Center (UCHC) to support regional priority setting efforts particularly as related to standardizing the focus group process. A set of suggested focus group questions and probes were developed with the assistance of RMHB and RAC representatives. A UCHC qualitative research associate provided support to the RMHBs/RACs as needed and attended most focus group sessions. Nonetheless, there were variations in how each region chose to conduct its qualitative assessment.

Mental Health Services

Availability – Provider Responses

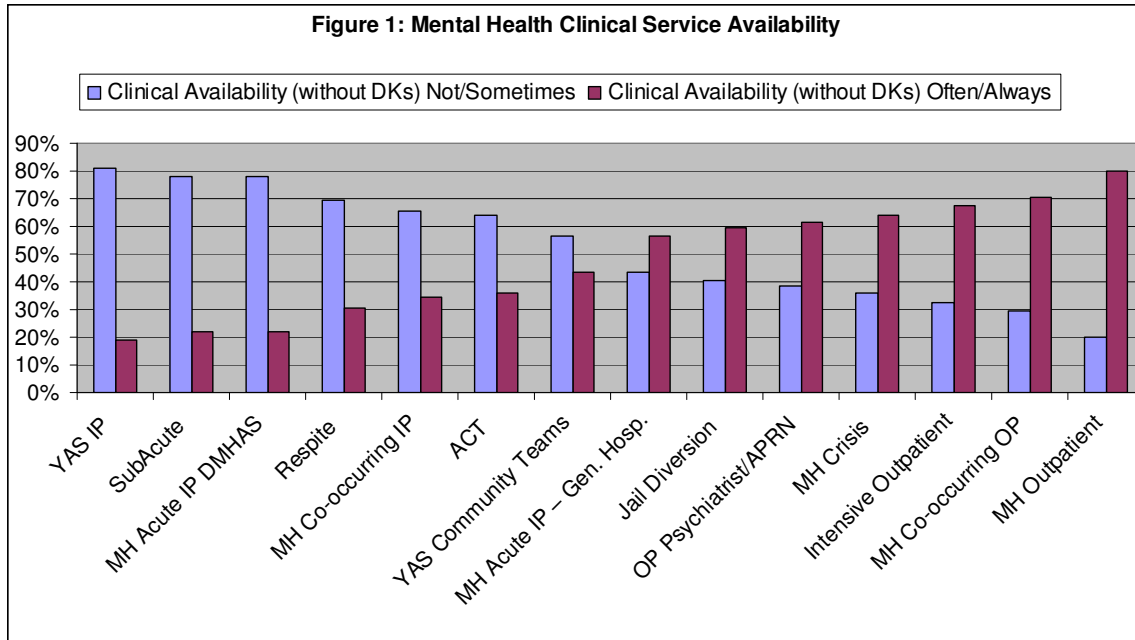
Mental health service providers were asked to rate the availability of clinical and support services based on their experience with clients they served directly in their agency and/or referred outside their agency. Response categories included “not available”, “sometimes available”, “often available” and “always available”. Respondents were instructed to answer “don’t know” if they were not familiar with the service. A total of 94 DMHAS funded (community-based, private nonprofits) and operated provider agencies responded to some or all questions, of which 89 stated they either provided both (N=68) mental health and substance use services or mental health only (N=21). Only one questionnaire per provider agency was allowed except in the instance that a provider delivered services in more than one DMHAS region. In that case, they were asked to complete one survey for each region based only upon the services delivered in each of the regions.

Services found to have limited availability (not available or sometimes available) for mental health clinical services included the following:

- Young Adult Services (YAS) inpatient
- Subacute Inpatient
- Acute Inpatient (DMHAS Operated)
- 24-hour Respite
- Co-occurring Residential
- Assertive Community Treatment
- Young Adult Services (YAS) Community Teams
- Acute Inpatient – Community General Hospital

All of the above clinical services having limited availability had more than 50% of providers rate the service as **not available or sometimes available**.

Figure 1 below displays responses for the fourteen mental health clinical service types included in the questionnaire. It should be noted that the analysis was based upon responses **excluding** “don’t knows” (DKs). DKs ranged from a low of 3% for Outpatient to a high of 39% for YAS Community Teams. Not all agencies either provided certain services or referred clients to them and therefore did not have an informed perspective. Provider survey results with and without DKs can be found in **Appendix A** of this report. Outpatient services, including co-occurring, intensive, and standard, received the highest ratings of availability, along with crisis services, medication management, and jail diversion.

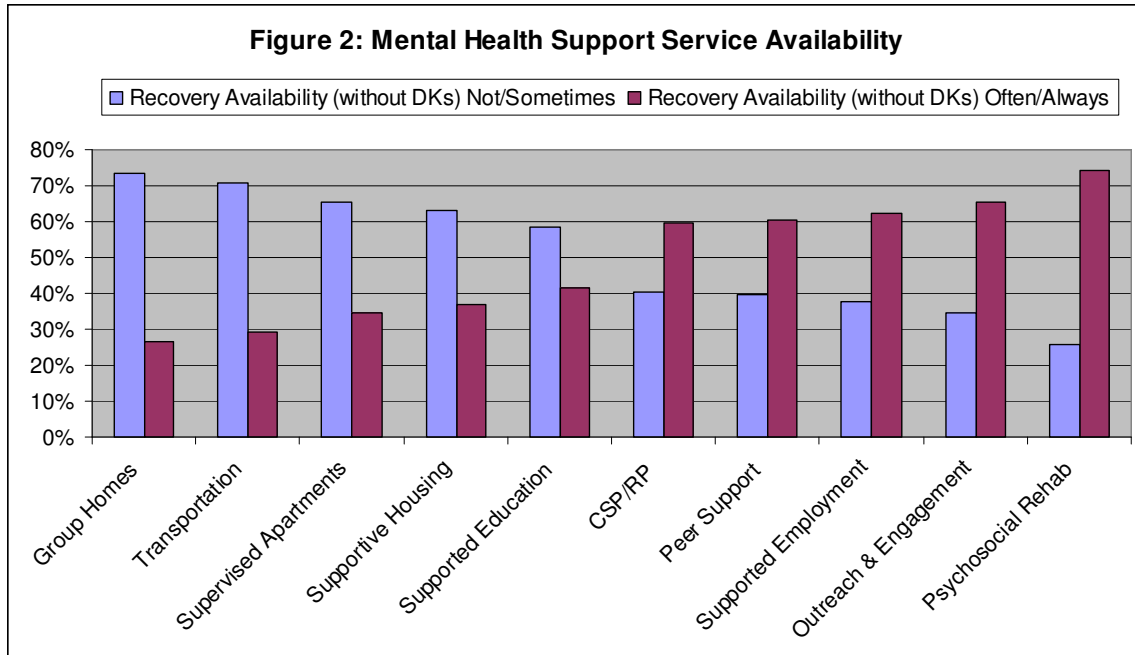


Providers were also asked to rate the availability of mental health **support services**, i.e., services that assist persons in their recovery and promote a life in the community. More than 50% of provider respondents rated the following support services as having limited availability:

- Group Homes (licensed)
- Transportation Services
- Supervised Apartments
- Supportive Housing
- Supported Education

The top four support services having the least perceived availability are related to housing and transportation; two areas that have been rated consistently as being priority unmet needs in past assessments. “Don’t know” responses for the above services with limited availability ranged from 6.1% to 15.3% - somewhat lower than for mental health clinical services.

Figure 2 below displays **all ten** support services included in the provider survey questionnaire. Again, this analysis excluded DKs ranging from 5% - 19%. As the proportion of DKs was lower for recovery vs. clinical services, it would appear that provider respondents have greater interaction with the DMHAS recovery system. Support services rated as “always” or “often” available include case management/CSP, peer support, supported employment, outreach & engagement, and psychosocial rehabilitation.



Qualitative Findings

Summary of Focus Groups

For 2012, the RMHBs selected key areas of importance to guide their local needs assessments. These included: 1) **age-appropriate services for young people** who are newly diagnosed (who are not eligible for DMHAS' Young Adult Services programs) and **older adults**; 2) **integration of medical care** and medical issues for DMHAS clients with a serious mental illness; and 3) **access to care** relating to gaps and barriers at several specific entry/discharge point including Inpatient, EDs, Incarceration, and Shelters.

Age-Appropriate Services – Young Adults:

Availability of services for this population was reported by all regions as limited. For instance, the Eastern Region noted a “severe need” for residential services and in the South Central Region, specific mental health and recovery services such as vocational supports, supported education services, mobile crisis, respite and inpatient care were described as lacking. In the South West Region, the primary need identified was for age-appropriate young adult (including college students) recovery services. In several regions (South Central, North West and Eastern), young adults and providers reported a lack of available individual group therapy for this age group.

Repeatedly, young adults and their family members, along with service providers, stated that this population has difficulty connecting with or may be uncomfortable socializing and interacting with older (and sometimes more symptomatic) adults. Thus, young adults are often reluctant to connect with recovery programs and social clubs which they perceive as not geared for them. This adds to the difficulty of engaging this age group in

care. Several participants noted that many young adults are mostly interested in vocational and educational supports. But many programs won't address these needs if the individual is not in treatment. However, engaging youth first in something that interests them (such as vocational services) can be a means to encourage them to seek treatment. Furthermore, young adults emphasized the need for work skills training as well as volunteer experiences that would add to their resumes.

It was reported that this population often lacks resources for independent living, such as income, entitlements, and housing. In three regions, Eastern, North Central and South Central, the need for basic life skills training for young adults, such as maintaining a living space, money management, vocational skills, utilizing public transportation and social skill development, was identified as a need.

The second greatest barrier faced by young adults is housing and homelessness, as identified by the same three regions. South Central identified housing as "often or always" a barrier for young adults. The North Central Region found through surveys and focus groups that housing is the primary service need for young adults living with mental illness. Landlords are reportedly wary of renting to young adults due to lack of a credit history and their age. In addition, in the South Central and North Central Regions, housing authority staff discussed the need for increased communication with Local Mental Health Authorities (LMHAs) and housing staff regarding young adult residents who may decompensate or lack independent living skills. Housing Authorities are interested in collaborating to assist this population but are often met with barriers due to state and federal confidentiality requirements.

Providers in the Eastern and South Central Regions were concerned with the increasing numbers of homeless young adults with behavioral health needs. Both of these regions reported that many young adults (not served by YAS programs) are not connected with any [DMHAS] services and are homeless, "couch surfing" or staying with friends because they do not have a home. Both regions felt that increased homelessness outreach is needed to identify and connect with these young adults.

Age-Appropriate Services – Older Adults:

The specific barriers to care and recovery faced by the elderly/older adult behavioral health client arose as a secondary theme in several focus groups throughout the state. In addition, the North Central Region explored this subject in greater depth through a focus group dedicated to the topic by providers, family members, and consumers.

Across regions, providers reported an increasing number of older adults (over 60) in treatment, many with complicated medical co-morbidities. This creates additional challenges for agencies to manage these increasingly complex medical needs. Age-appropriate services for the elderly are reported to be very limited, including socialization, substance use treatment, geriatric psychiatry, and in-home care. In the North Central Region, participants report that there is a three-month waiting list for an appointment with a geriatric psychiatrist. Behavioral health services in general are not

specialized for older adults. There are few professionals trained in geriatric psychiatry and few geriatric inpatient units. Furthermore, focus group participants identified the need for skilled “geri-psych” nurses and case managers in emergency rooms along with appropriately trained mental health clinicians and home care professionals. Late onset alcoholism due to isolation and addiction from misuse of prescription and pain medication were raised as concerns as well.

Many older adults do not have family supports for daily living and service coordination. In addition, it was found that many older adults remain socially isolated and that there is “not enough” outreach by the behavioral health system to this population. Senior Centers and Adult Day Care Centers are often not welcoming to clients with severe and persistent mental illness and/or individuals with complex medical problems. In fact, senior center staff may not be adequately equipped to serve this population. At the same time, it is reportedly a challenge for psychosocial clubs to manage some of these elderly clients, leaving them without options for socialization. Focus group participants also reported transportation and “stigma” [and discrimination] as barriers for the older adult client in need of behavioral health services.

According to focus group participants in the North Central Region, older adults with behavioral health problems risk homelessness, home insecurity, and poverty due to a shortage of affordable housing with appropriate supports such as assisted living and services to maintain people in their homes and communities.

Accessing Services

Difficulty **navigating and understanding the behavioral health system** was an overwhelmingly consistent theme in focus groups across all regions. Providers, families and consumers alike voiced frustration with changes in service and resource availability. One provider in the North West Region stated that, “staying on top of the changes is a full-time job.” Both inpatient and outpatient mental health and addiction services were reported to be confusing, cumbersome and uncoordinated by providers, consumers and family members.

Issues with “211” (United Way Infoline) referrals came up frequently in focus groups – some participants stated that they can never get through to an operator due to busy signals and long hold times. Others stated that they will call every agency referred to by 211 and none will be accepting new clients or they will have very long waitlists. In addition, different eligibility and other requirements among providers can be confusing for some. Determining entry points for the behavioral health system was frequently cited as challenging. The emergency department (ED) has become the primary entry point for many, leading to long and unnecessary wait times. In addition, ED focus group participants stated that trying to navigate the system for clients is time consuming and contributes to back-ups in ED waiting rooms. Participants explained that crisis clinicians in EDs get “really bogged down” with finding services and resources in the community and helping patients to access appointment. One ED physician stated that crisis clinicians spend half of their time doing this type of case management, which is an unreimbursed

service. An ED physician in the South Central Region stated, “I don’t know how to get people into the system in some coordinated fashion.”

Referral organizations such as town social service workers were also frustrated by constant changes in the system and the lack of coordination and communication within the system. Town social service workers, police officers, firemen, church groups and others reported the most difficulty with helping individuals navigate the system. It became clear throughout the qualitative process that many people in the community do not know how to find their way through the system or become incredibly frustrated at the difficulties they encounter in trying to access services. Some town social service staff felt they “used to know the system”, then people or processes changed at an agency and they lost their connection.

Inpatient Care

Focus group participants in every region throughout the state identified **problems with accessing inpatient treatment** for behavioral health, including long-term, short-term and sub-acute. Providers from the community and ED voiced frustration with accessing inpatient psychiatric beds. They noted a lack of consistency regarding what inpatient services are available and difficulty determining how to access them. Overall, a trend towards shorter inpatient stays in community (general hospitals) inpatient beds was noted, with an average stay of a week or less. Furthermore, a **shortage of respite beds** throughout the state was a common theme in every region. Participants identified both of these shortages as leading to re-hospitalizations and inappropriate ED visits. The shorter lengths of stay in acute community general hospital inpatient settings was compounding problems especially when patients were unable to access outpatient services quickly after discharge. Given the trend to shorter lengths of stay for inpatient hospitalization, the lack of prompt access to outpatient and prescriber services impedes the chances for recovery and may result in re-hospitalization. In one region it was stated that all too often people are sent home from an inpatient psychiatric hospitalization without a treatment or coordination of care plan increasing the likelihood of readmission.

Outpatient Care

Consistently, **waiting for outpatient behavioral health services** was raised as a major barrier to care and recovery. Wait times for an initial assessment at an outpatient clinic varied across regions but ranged from two to six weeks (average wait time as reported in the Provider Survey was 13 days) as reported in the North West Region. In the South Central Region, participants noted that there is a 30-day wait for an initial assessment and then patients routinely wait 6 – 8 weeks for a medication appointment. In the Hartford area, participants described new intake policies requiring an orientation as a major barrier to care. They described an elaborate intake process which some outpatient clinics require including a multiple day “orientation” before receiving an initial assessment. In the New Haven Region, participants stated that wait times are also a major barrier, but outpatient clinics are “doing the best they can.”

In some regions, focus groups spoke about how wait times impact patients leaving an inpatient unit or inmates released from Corrections: “when coming out of the hospital they need everything at once and need it really fast...the system is not friendly to new entrants.” This results in a cycle in which a patient released from an inpatient setting or a behavioral health ED admission cycles back into the hospital or the ED as there are no supports while waiting for outpatient treatment. The long wait times for medication and outpatient health care services is concerning as “timely client engagement” is important for successful recovery.

The need for **“bridge” or interim care** for patients after a hospital or ED discharge while waiting to begin outpatient treatment was a major theme of focus groups throughout the state. Shelter and ED staff as well as inpatient providers reported that some inpatient psychiatrists and ED physicians will continue to prescribe for patients for several weeks after discharge until they are connected with an outpatient provider. The need for coordinated care, medication management, and some type of peer supports during the interim period was cited often as a critically needed service.

The North Central Region specifically addressed, in one focus group, the problems facing individuals leaving incarceration. In addition, this topic arose naturally in focus groups in all regions, including two ED focus groups. Overall, participants agree that the DMHAS Jail Diversion program is working very well and that communication between the Department of Correction (DOC), DMHAS and the Courts is strong. Two regions, Eastern and South Central, did not report any problems with Jail Diversion programs or with unplanned jail releases; however, South Central did report a need for more resources for those services.

Release of individuals from prison/jail without entitlements and referrals has improved somewhat but continues to be an issue, particularly with unexpected and unplanned releases. In several focus groups, participants noted that prisoners are frequently released from court without any medications, prescriptions or entitlements. In addition, prisoners are reportedly released with nothing “except the clothes on their back”. As these releases are unexpected and unplanned, very often the released inmate does not have the necessary documents needed to obtain entitlements. It was noted in one group that DOC jails and prisons do not have voicemail systems, which can complicate pre-release planning and community referrals.

At the Bridgeport ED, focus group participants stated that released prisoners are dropped off “several times a month” in the ED by prison staff, as they have nowhere else to go to obtain medications and entitlements. Individuals may remain in the ED for several days while entitlements are secured and are then often admitted to the hospital for behavioral health treatment. This situation was identified by most regions with key informants reporting that correctional inmates are being released from prison (or directly from court) without medications or a referral to community services. In a focus group in Hartford, participants reported the same issues and described how re-entry individuals end up in shelters for long periods of time because they have no services. While providers admit that this group is a small part of the population, it remains a difficult problem needing to

be addressed. In the North West Region, it was noted that coordination of services for inmate releases from Garner Prison has improved. In the South West Region, participants reported difficulties for ex-offenders to access some recovery services. Other issues facing the re-entry population include limited housing and work options for individuals with histories of fire setting, assault or sexual offenses.

Integration of Medical Care and Behavioral Health

Another priority area identified by the RMHB was the “integration of medical care and medical issues for adults with serious mental illness.” Specific questions explored within this topic included:

- How well is primary care and behavioral health integrated for DMHAS clients?
- What is the role of Federal Qualified Health Centers (FQHCs) in the delivery of behavioral health care?
- How well are FQHCs collaborating with behavioral health providers?
- What is the capacity of the current mental health and addiction services system to address the increasingly complex medical co-morbidities of an aging DMHAS population?

The North Central Region conducted two focus groups on the topic of older adults with medical concerns which addressed some of the questions above. In the remaining regions, these issues were discussed as general comments raised within focus groups.

Overall, focus group participants were concerned that DMHAS clients are aging and have higher rates of co-morbid medical issues than the general population. In addition, community providers reported increasingly complicated medical issues among the behavioral health population. This has placed a strain on resources and provider staff. Many programs, particularly residential programs and shelters, are not currently equipped to manage these medically compromised clients. One shelter director in the greater Hartford area reports that she has to turn away referrals weekly as she cannot safely serve those with complicated medical problems.

There were differing opinions amongst providers regarding the quality and effectiveness of integrated medical and behavioral health care. In the South West Region, in order to obtain behavioral health services at a FQHC, it is required that patients also obtain their health care there, promoting integrated behavioral health and medical care. According to their regional report, “coordinated efforts have ensured that consumers’ mental health and physical health needs are being met, which in turn improves their overall health.” In the Hartford area, some providers felt that persons recently discharged from inpatient hospitalization and DOC inmate re-entry populations had difficulty in receiving primary care due to lack of entitlements which creates a barrier to obtaining needed medications.

Two regions, the North West and East, reported problems with access to primary care and specialists. In the North West Region, it was reported that the newly opened FQHC is closed to behavioral health patients, creating a barrier to accessing integrated medical and

behavioral health care. This region also reports that EDs are frequently utilized to access primary care by the behavioral health population. In the Eastern Region, there is concern that access to medical care has worsened, reportedly due to local physicians refusing to accept new Medicare patients; however, access to the FQHC is very good. Despite the concern about access, providers in the Eastern Region reported that “community collaborations have helped make new in-roads and partnerships among community organizations [which] has helped to better align primary care and mental health services.”

In several regions, there were some concerns raised in terms of how well FQHCs are collaborating with the behavioral health system. A common policy of most FQHCs is a medical screening or physical prior to obtaining behavioral health care services. This can delay a patient from receiving psychiatric medications by several weeks. Another concern is the low tolerance these clinics have for patient noncompliance. Issues such as missed appointments or substance use can lead to discharge from treatment, leaving these individuals without care. Coordination between primary and behavioral health care was one of the top five barriers identified in the 2012 DMHAS Provider Survey as hindering access to or continuing mental health care. For these reasons, it would appear that this identified need area would benefit from further exploration and discussion.

Three regions mentioned access or quality of dental care in their reports (North West, Eastern and South West). Overall, these regions report that access to dental care for individuals on entitlements is poor and that there are long waiting lists for dental appointments. In the Eastern Region, the only non-profit dental clinic, which is located in the southeastern area of the region, has a waiting list of a year and individuals have reported difficulty getting emergency dental appointments. In the North West, many focus group participants stated that they did not feel their dental care needs were adequately met, while in the South West, one provider indicated that the majority of consumers over 40 have dentures due partly to a lack of preventative dental care. Routinely, entitled clients must wait for a dental emergency before being able to receive care, necessitating an emergency extraction rather than tooth preservation.

Barriers

The provider survey included a section on barriers to services that hinder getting or continuing services. These 18 barriers were related to: 1) providers’ operational issues (e.g., sufficient staffing, hours of operation, or qualified workforce), 2) service coordination (between mental health and substance abuse, human service or primary care providers), or 3) other service delivery concerns (e.g., client engagement, eligibility criteria, medication side effects).

The top five barriers that hinder receiving or continuing mental health services included:

- Lack of Housing
- Lack of Transportation
- Lack of Adequate Staffing
- Lack of Child Care

- Coordination between Primary and Behavioral Health Care (new to the 2012 survey)

Figure 3 below displays the results of the provider survey vs. the qualitative findings from the regions regarding barriers to mental health services. Both assessments ranked housing, transportation and coordination between primary and behavioral health in the top five. Of note is the barrier raised consistently in all regional qualitative assessments, namely difficulty in navigating services. Care Coordination for inmates return to the community was also one of the top five raised in focus group discussions.

Housing and transportation have been long identified barriers. In both of these areas, DMHAS has limited resources to affect change. While all levels of government have focused efforts at increasing the availability of affordable housing, there exists strong evidence that such housing is still out of the reach of many disadvantaged Connecticut residents. This situation has grown worse by the difficult economic environment of the last four years. Inroads to alleviating gaps in public transportation also have not met with adequate resources or policies that would support better access to the kind of recovery supports (employment, housing, socialization) needed by DMHAS consumers.

Figure 3: Barriers to Mental Health Services

Provider Agencies: Top 5 Service Barriers	Always or Often a Barrier		Focus Groups: Top 5 Service Barriers (not in rank order)
Lack of Housing	66.0%		Difficulty Navigating System
Lack of Transportation	58.8%		Lack of Housing Options (especially for young adults)
Lack of Adequate Staffing	46.9%		Transportation Services
Lack of Child Care	44.3%		Care Coordination for Inmates Re-entering Community
Coordination between Primary and Behavioral Health Care	43.3%		Coordination between Primary and Behavioral Health Care

Regional Analysis and Variations

As noted, each region was responsible for developing a Regional Priority Report based upon the regional survey findings, personal interviews with key informants, focus groups with consumers, family members and treatment providers, and other local needs assessment information.

DMHAS conducted an analysis of the **regional provider survey findings** to determine similarities and differences from the statewide results. For the most part, as would be expected, regional results mirrored the statewide findings. The following is a brief summary of that analysis. It is highly recommended that the regional reports be read in order to understand the differences in local service system structures that drive the regional priority needs identified.

Mental Health Services and Barriers

Statewide findings mirrored those mental health clinical services found to have limited availability within each region. As Figure 4 shows, only Young Adult Services Community Teams was found to have limited availability in only one of the five regions. Inpatient and residential services were those identified across the majority of regions as insufficient according to providers' responses in the 2012 survey.

Figure 4: Regional Mental Health Clinical Services with Limited Availability

Service	Number of Regions Reporting Limited Availability
Acute Inpatient - DMHAS	5
Young Adult Services Inpatient	5
Respite Care	4
Sub Acute Inpatient	4
Co-occurring Residential	3
Assertive Community Treatment	3
Young Adult Services Community Teams	1

Looking at access to mental health support services (Figure 5), most regions reported housing services (i.e., supervised apartments and supportive housing) and transportation as those recovery supports being limited in availability, similar to past priority setting assessments. Group homes were also found by most regions to be lacking in availability along with supported education and peer-to-peer services. Outreach and engagement, psychosocial rehabilitation and case management (not shown below) were seen as having poor availability in only one region each.

Figure 5: Regional Mental Health Support Services with Limited Availability

Service	Number of Regions Reporting Limited Availability
Group Homes (licensed)	4
Supervised Apartments	4
Transportation	4
Supportive Housing	3
Peer-to-Peer Services	3
Supported Education	3

Turning to barriers (Figure 6) that hinder accessing or continuing mental health services, housing within all regions and transportation in all but one region were seen as the most significant (always or often) barriers. This has been the case in a number of previous priority setting reports, although there have been some gains in housing affordability and availability. Insufficient staffing, i.e., too few staff for service demand, also was a top ranked barrier across the state. The next set of barriers were found in two regions and included long waitlists, lack of child care, payment requirements and, newly added to the 2012 survey, lack of coordination across behavioral health and primary care providers.

Several barriers were particular to only one region such as workforce development, length of stay limitations, and client engagement.

Figure 6: Regional Mental Health Barriers

Barrier	Number of Regions Reporting Limited Availability
Lack of Housing	5
Insufficient Staffing	5
Lack of Transportation	4
Long Wait Lists	2
Lack of Child Care	2
Payment Requirements	2
Coordination between Primary & Behavioral Health Care	2
Workforce Development	1
Length of Stay Limitations	1
Client Engagement	1

Recommendations – Mental Health Services

Service System Access & Navigation

One major area identified by the various stakeholders who contributed to the 2012 Priority Setting Process concerned mental health services access. This was characterized by too few services, a lack of coordination or a fragmented and confusing system. Below are recommendations offered to address some of these service system concerns.

Service Coordination and Enhancements

- Develop opportunities and practices with supported employment providers to share ideas/resources
- Promote collaboration between state agencies, hospitals, community health centers, Local Mental Health Authorities, and ValueOptions to create processes for same day access to outpatient, prescriber, and intensive care management after discharge from inpatient hospitalization
- Open provider meetings quarterly to inform interested stakeholders (e.g., referral agencies) of service changes, issues, and other areas of mutual interest
- Implement routine trainings for referral agencies and first responders on local service systems
- Continue to work with local police *leadership* to build or rebuild support for Crisis Intervention Teams (CITs) in departments that have lagged or lapsed in CIT training and commitment. The goal should be CIT officers on every shift in every town
- Make cooperation and participation across providers and other service systems a contract requirement

Service Expansion

- Identify champions of supportive housing who will advocate to resolving the housing issue
- Increase the number of private and agency-based therapists that accept Medicaid/Medicare coverage for one-on-one counseling sessions- explore best practice models, convene therapists to better understand how this may be accomplished and provide an on-line list of therapists
- Expand Crisis Intervention Team (CIT) services: Offer more CIT-type training to police and other first responders (e.g., EMTs) including the Hearing Voices workshop and consumer presentations
- Increase access to case management services to ensure coordinated wrap around services and/or increase capacity of residential case managers to provide wrap around services
- Expand inter-departmental funded programs between the Department of Correction and DMHAS
- Develop a range of housing, vocational, and case management options for people with varying needs and backgrounds
- Continue to support all forms of housing services
- Increase trauma informed services

Service Navigation

- Create navigator positions to assist persons accessing care – not just a referral but through admission and first appointment
- Actively recruit consumers as engagement specialists and crisis workers, both at Mobile Outreach and in hospital EDs

Services for Priority Populations

It is now well recognized that services tailored to the distinct needs and interests of individuals with a mental illness result in improved service engagement, retention, and outcomes. In 2012, two populations were the focus of the RMHB needs assessment process, namely young (age 18 – 26) and older (age 60+) adults. Both these service populations pose unique challenges to the current mental health service system. Refocusing services to be more engaging and supportive can provide lasting benefits. As stated in one recommendation regarding young adults: “Our approaches to marginal youth have failed to draw them into the system or the community. We need more empathy, imagination, and active engagement.”

Young Adults

Service Coordination and Enhancements

- Institute training on age-appropriate service models for all providers serving young adults, i.e., expand Young Adult Services (YAS)-informed training to everyone
- Criminal justice collaboration to assure that young adults get treatment instead of incarceration
- Training for residential staff in providing life skills (for independent living – money management, social interaction, vocational, etc.)
- Increase partnerships with higher education institutions
- Streamline access to needed mental, behavioral, and physical health care services
- Promote recovery supports first such as housing and vocational training that provide some tangible immediate results that young adults are most interested in; then move towards treatment engagement

Service Expansion

- Increase Bureau of Rehabilitative Services for young adults
- Increase access to transitional, affordable, and supportive housing for those not eligible for Young Adult Services
- Provide outreach and expansion of supported employment and supported education services
- Generally, expand age appropriate services across the service system to better meet the unique service needs of young adults

Service Navigation

- Develop a web site for young adults that will engage them and serve them as a way to reach out to those needing mental health services
- Design or adopt an electronic/virtual system that would assist young adults to enhance their own mental health, and address mental health issues as they arise or develop in an anonymous and non-threatening venue

Other

- Secure representation of young adult representatives on DMHAS advisory bodies
- Formally support initiatives that are spearheaded by young adults, e.g., Young Adult Recovery Conference 2012

Elderly

Service Coordination

- Expand outreach and collaborative efforts with existing social network organizations (such as senior centers, churches, libraries, etc.) to disseminate mental health information
- Provide more training and consultation on earlier intervention techniques such as Mental Health First Aid
- Enhance discharge planning from hospital emergency departments and general hospitals
- Promote intersystem collaboration through a mental health and aging coalition whose aim is to improve policy and practices in the care of older adults
- Conduct training and promote workforce development to increase the numbers, clinical skills, and cultural competencies of professionals who work with older adults

Service Expansion

- Promote more in-home psychiatric care
- Continue to explore and develop innovative programs for intensive care management, coordination with primary and specialty health care and follow-up care coming out of the hospital
- Provide training and support to families who are caring for older adults with serious mental illness and substance use disorders
- Promote expansion of Money Follows the Person, Elder Home Care, and Mental Health Waiver programs and affordable assisted living to meet the growing demand

Service Navigation

- Continue and expand outreach and engagement efforts for older adults with serious mental illness and substance use disorders

Integrated Care

Serving the needs of persons with behavioral health care needs requires a holistic approach, one that understands the mind/body connection. Primary and behavioral health care must move to a seamless system in which there is no wrong door and services are comprehensive and well coordinated. Integrated care is an integral component of where the state is headed and a cornerstone of healthcare reform. Not all regions addressed this priority area, but several recommendations were noted in regional priority reports.

- Assist to secure dental coverage for consumers
 - Develop an inventory from providers and consumers of effective strategies to improve dental care amongst consumers

- Develop basic dental care trainings for consumers and staff in conjunction with state and local resources; i.e., look at causes that are unique to consumers with mental health and strategies to improve care
- Provision of resources to implement smoking cessation pre-contemplation and treatment groups
 - Develop capacity for providers to provide training on how to implement smoking policies, practices, and services
- Work with colleges to increase access to mental health supports
 - Promote anti-stigma/discrimination campaigns, peer driven initiatives and suicide prevention
- Promote and organize local and regional Mental Health First Aid trainings
- Provide regional trainings on suicide trends and prevention across the life span

Substance Abuse Services

Availability – Provider Responses

As with mental health service providers, substance abuse provider agencies were asked to rate the availability of clinical and support services based on their experience with clients they served within their agency and/or referred outside their agencies. Response categories included “not available”, “sometimes available”, “often available” and “always available”. Respondents were instructed to answer “don’t know” if they were not familiar with the service. A total of 94 DMHAS funded (community-based, private nonprofits) and operated provider agencies responded to some or all questions of which 73 stated they either provided both (N=68) substance use and mental health services or substance abuse services only (N=5). Only one questionnaire per provider agency was allowed except in the instance that a provider delivered services in more than one DMHAS region. In that case, they were asked to complete one survey for each region based only upon the services delivered in each of the regions.

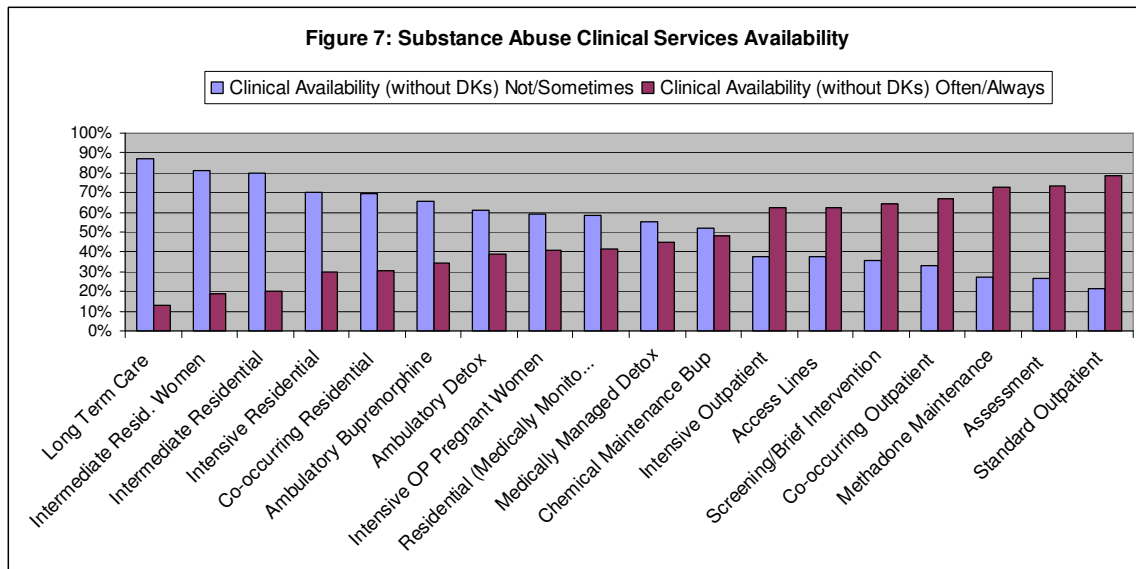
Services found to have limited availability (not available or sometimes available) for substance abuse clinical services included the following:

- All Levels of Residential Care (long-term, intermediate and intensive)
- Intermediate Residential – pregnant women
- Co-occurring Residential
- Ambulatory Detoxification (including Buprenorphine)
- Intensive Outpatient – Pregnant women
- Residential and Hospital Based Detoxification
- Chemical Maintenance/Buprenorphine

The above clinical services had limited availability with more than 50% of respondents rating the service as **not available or sometimes available**. It should be noted that these service types had “Don’t Knows” (DKs) response rates ranging from a low of 14.0%

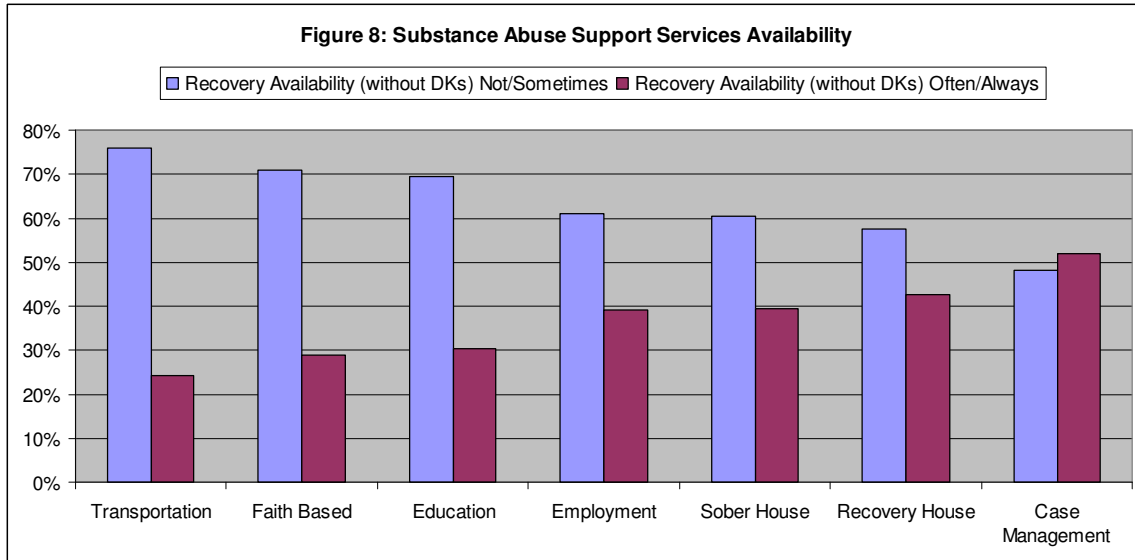
(Intensive Residential) to a high of 35.1% (Intensive Outpatient – Pregnant Women). Overall the range of DKs spanned from 10.6% to 35.1%. Again as was the method used to report availability of mental health services, DKs were excluded from the substance abuse services analysis.

Figure 7 below displays responses for all 18 service types included in the provider survey questionnaire. Standard and intensive outpatient services, screening and brief intervention, assessment, access lines and co-occurring outpatient services all received high ratings of availability.



Providers were asked to rate the availability of substance abuse support services, i.e., those that assist persons in their recovery and promote a life in the community. With the exception of case management, all categories of recovery support services were rated as having limited availability (Figure 8) including:

- Transportation
- Education
- Employment Services
- Sober Housing
- Faith Based Services



Similar to the results for mental health support services availability, addiction recovery supports perceived as lacking in availability included education, housing and transportation services. Faith based services was ranked much lower in its availability in 2012 than 2010 with only one quarter stating it was available “often or always”. On the other hand, faith based services did have the highest percent of provider respondents stating they weren’t familiar with the service (27.4%).

Qualitative Findings

Summary of Focus Groups

Substance abuse issues were explored through various qualitative methods throughout the state by both RACs and RMHBs. Some RACs conducted focus groups utilizing DMHAS *Priority Setting Framework* questions while others employed their own questions. In some regions (South West, South Central, and North Central), RACs and RMHBs jointly conducted focus groups while in other regions focus groups were conducted independently by RACs. A total of sixteen focus groups specifically dedicated to the topic of substance abuse were conducted across the state. Participants included persons in recovery and parents of young adults who are in recovery or who are currently abusing substances. A subset of these parents had experienced a substance related death of a young adult child. Others who participated in substance abuse focus groups included social workers, police, town social service and youth service workers, and physicians. In addition, substance abuse related information arose from the hospital emergency departments (ED) focus groups and from the general focus groups held by RMHBs. As substance abuse issues were not always explored in a consistent manner, drawing generalizations from the qualitative process was somewhat difficult.

Special Populations

Young Adults

Many of the perspectives and comments mentioned in the Mental Health section of this report regarding services for young adults also related to those with substance use disorders. Young adults with substance abuse issues have needs specific to their age, maturity and developmental stage. Young adults report difficulty connecting with older adults who make up the majority of clients in substance abuse programs. In addition, young adults may not see the experience of their older peers as relevant or may not feel respected or understood by them. The lack of age appropriate services was seen by providers as one of the major reasons for dropping out of substance abuse treatment. Additionally, recovery supports are limited for this age group with providers reporting that many young adults “want to do better but need better support for education, job search, sober housing, young adult recovery supports, mentors, etc.” These young adults are seen as needing skills training for independent living and recovery, but often drop out of treatment before obtaining these skills.

Overall focus group participants reported variations in service availability and accessibility within regions as well as across regions for young adults. As is the case generally, inpatient and residential rehabilitative treatment (including intensive, intermediate, and long-term) is very limited for this population. Waitlists for outpatient substance abuse services also varies with some regions having more capacity than others. Rural areas of the state pose a unique challenge as services cluster around urban pockets and public transportation is lacking. The Eastern Region reported that Al A-Teen and other age appropriate mutual help group are limited in rural areas and even when they do exist, transportation may still be a barrier. Similar to the findings in the mental health assessment, focus group participants reported that access to and navigation of the system can be especially challenging for this population.

Lesbian, gay, bisexual, and transgender (LGBT) young adults were also noted as having unique needs – many do not feel safe in recovery programs and would prefer specialized services. LGBT young adults also have high rates of homelessness, substance abuse, alienation from family/parents and fewer resources.

Another concern was raised in two regions (North Central and North West) regarding the existence of program eligibility requirements preventing young adults from accessing substance abuse treatment services. For instance, it was reported that several young adults at the Faces of Recovery Listening Forum described instances when they were turned away from detoxification (detox) programs, because they weren’t “high” enough (North Central).

Finally, the special needs of young adults who are pregnant or parenting was raised in the Eastern Region. Challenges such as child care or fear of losing custody of their child(ren) can be barriers to seeking substance abuse treatment.

Elderly

There is concern and increased awareness of the vulnerability of the elderly to prescription drug addiction and other substance abuse issues. This is an emerging issue which RACs and community providers are paying close attention to. It was noted in several regions that there are no or limited substance abuse programs specific for older adults. Also medical and behavioral health staff as well as referral agency staff are not educated and trained to recognize and treat older adults with substance use issues.

Women

The need for more gender specific programs and groups for women was raised in a few regions (North West and Eastern). Particularly, services for women with children were identified as an unmet need. The understanding that women in recovery face different barriers and have different needs from men was recognized. Furthermore, the need for a support network of providers and peer mentors who realize the “woman as a whole” who has physical, emotional, and spiritual needs during the recovery process was identified.

Ex-offenders

Persons in recovery with criminal histories, particularly those with arson or sexual offense records, face a severe lack of services. It is incredibly difficult for these individuals to obtain housing, employment and other services. These individuals are also often “hopeless” about their recovery and their limited options serve to reinforce their hopelessness.

Drug-free Safe Environments for Persons in Recovery

A primary theme that evolved from the focus groups was the need for drug-free, safe environments for individuals in recovery. This includes both immediately post-detox and over the long-term. Both sober houses and other group quarters were reportedly in limited supply throughout the state. Furthermore, many of these programs operate “off the grid” resulting in limited awareness of these programs. Participants frequently described having nowhere to go after detox or having to return to environments where family members were continuing to use. It is important to note that this topic arose naturally in all of the focus groups as opposed to facilitators directing the conversation.

Focus group participants in four regions discussed a need for siting sober houses and residential programs in areas outside of inner cities and neighborhoods where drugs are readily available. In Bridgeport, participants described how “sober houses” were sited in areas with easy access to drugs and “where you see people using” and where “you see drug transactions everywhere”. One woman expressed dismay that a “beautiful new sober house” recently opened “right up the street from the crack house...so you have to walk by the crack house to get to the sober house.” Participants expressed frustration with the situation stating: “I can’t get clean here” and “you wonder why so many people fail”. On the other hand, participants pointed to the difficulty of siting sober houses and residential

programs in safe neighborhoods due to opposition from the community: “people are fussy [in that neighborhood]...they say, we don’t want those people here.”

Service Access and Availability

Several systems issues were brought up as barriers to recovery from substance abuse. First, a persistent theme was the difficulty in navigating the substance abuse system, particularly for family members. Family members stated that they were very often unaware of available services or how to access them. Some reported having to hire third party insurance specialists or using the Office of the Healthcare Advocate to obtain services. Consumers also reported feeling as if services were “hidden”. “We don’t know where to go, don’t know who’s who...We don’t know what services are offered; don’t know how to get from point A to point B to C.”

Another systems issues raised was barriers to accessing care by private insurance. Participants found fault with insurance companies which often determine the level of care based on policy coverage rather than on the person’s need. There was a sense among participants that insurance carriers often prohibited access to what the individual or family member felt was the appropriate level of care. In addition, there were complaints that outpatient is “always required as a first step” when “failure” at this level could have serious consequences.

Detoxification

Access to detox is reportedly limited (i.e., inpatient hospital based) in the North West Region; however, in the remaining areas this was not raised as an issue. Detox related issues that were raised included admission criteria excluding those with serious mental illness or those with complicated medical co-morbidities. Participants report that some facilities state they are not equipped to manage individuals with active symptoms of serious mental illness or those who may become medically unstable due to medication interactions or are medically compromised.

Use of emergency rooms for detox services was commonly reported in both general and ED focus groups. Many ED staff reported that police often bring intoxicated individuals to the ED to detox, to get them off of the streets. Many of these individuals do not want to detox, but have nowhere to go and opted to go to the hospital instead of jail. At some general hospitals detox occurs “under the radar” as some persons are admitted as either medical or psychiatric patients.

Long wait times to access detox (and residential treatment) were commonly cited. It should be noted that wait times for detox reported in the 2012 DMHAS Provider Survey averaged one day. Family members in particular were very concerned regarding the importance of accessing services promptly, as an individual could lose motivation, thus missing an important “window of opportunity”. In Bridgeport, CCAR members described longer wait periods. “They make you call to see if you really want to do it, but why should you have to wait...if you really want to do it [get treatment]?”

Residential – Intermediate and Long-term Care

Another recurring theme was the lack of intermediate care and recovery supports, described as a “critical bridge between detox or crisis services”. This theme was consistent in four regions (South West, South Central, North Central and Eastern). Across regions, providers and clients regularly discussed the need for intermediate residential services (i.e., greater than 30 days). Often, insurance will only cover an intensive residential treatment stay of less than 28 days; however, participants noted that this is not a sufficient length of treatment for individuals newly in recovery, especially after many years of substance use. For those accessing detox, the situation can be more difficult. Individuals receiving a three to five day detox stay are discharged with limited recovery supports or continued (e.g., intermediate) care. These individuals are described as having no where to go, either because family members may not be able to manage the stress of caring for or supporting them, or because family members themselves are continuing to use.

Residential substance abuse treatment is regarded as very effective overall; however, for those outside of the DMHAS system, access to this service is very limited, other than for wealthy individuals who can afford to pay for his service. Capacity within the DMHAS system for long-term residential was noted as being very limited.

Outpatient

Overall the quality of outpatient substance abuse treatment services is reported to be “strong” and a range of services available in most areas. The lack of methadone and/or Suboxone (i.e., Medication Assisted Treatment – MAT) was a commonly stated barrier to treatment, particularly in rural regions. Participants describe difficulty travelling out of town for treatment while managing competing demands such as bringing children to school or picking them up, work and other treatment meetings. Resistance from local residents or zoning commissions has been a barrier to siting these treatment centers outside of major cities.

Recovery Supports

Along with the lack of residential treatment services, participants report that persons in recovery often face a lack of community supports. In Bridgeport, one participant explained, “you need a person there in every stage...you need housing, food, clothes...need people to help you through until you are strong enough to be on your own...that is what is going to make the individual stay away from drugs.” Participants stressed that recovery supports were essential to help those recently discharged from treatment “get back on your feet and stay clean.” Lack of these recovery supports or “wraparound services” were consistently named as major barriers in the early stage of recovery, especially after detox. In the Eastern Region, the concept of “maximizing motivation” by ensuring access to services and supports at the point of detox was discussed as a necessity to prevent relapse. As clients experience roadblocks to recovery, their motivation can diminish. In addition, in the North West and South Central Regions,

there are no CCAR services (i.e., Recovery Center), which was consistently noted as a missing component in the recovery support network.

There were some concerns raised about Alcoholics Anonymous (AA) meetings restricting people who have co-occurring psychiatric disorders or for those with opioid addictions. Individuals using Methadone or Suboxone reported not feeling welcome in AA meetings. However, in areas where there are limited Narcotics Anonymous (NA) meetings, AA may be the only resource for those with opioid or other addictions. For those with co-occurring disorders, i.e., mental illness and a substance use disorder, there are even fewer recovery and support groups available.

Stigma and Discrimination

Stigma associated with addiction was a secondary theme raised by focus groups. Providers and persons in recovery reported continued and engrained stigma surrounding substance abuse and discrimination against individuals with addiction problems. Most participants agreed on the need to educate providers, physicians, and medical professionals regarding addictions and the disease model, and suggested that DMHAS can and should play a lead role in this effort.

Substance Specific Findings

Marijuana

Much attention was given to recently enacted legislation which decriminalized and “medicalized” marijuana. RACs and local prevention councils noted the increase in adolescents who view marijuana as “safe” or “harmless” and a misunderstanding among young people as to the legality of marijuana use and possession. The need to address marijuana prevention as a “legal” or “regulated” substance, in a similar manner as alcohol and tobacco, was emphasized. Furthermore, marijuana was identified as the “stepping stone” [gateway] drug for many youth.

Opioids

Addiction to opioids resulting from both legitimate and non-medical use of pain relievers, as well as increases in opioid overdoses, were significant concerns. Heroin was viewed as one of the primary substances for which individuals come to the ED for treatment. Several communities in Connecticut were found to have very high rates of overdoses in a recent study completed by Brown University.

Discussion of the rather low voluntary use by physicians of Connecticut’s Prescription Monitoring Program (PMP) came up as a concern. RACs and prevention councils advocate the mandatory use of this system and/or improving education and outreach to physicians regarding the benefits of the PMP. The potential for the PMP to identify prescription drug abusers early and to engage them in treatment is seen as an underutilized and important resource.

Barriers

The provider survey included a section on barriers to services that hindered getting or continuing services. These 18 barriers were related to: 1) providers' operational issues (e.g., sufficient staffing, hours of operation, or qualified workforce), 2) service coordination (between other substance abuse, mental health, human service providers and primary care), or 3) other service delivery concerns (e.g., client engagement, eligibility criteria, medication side effects). Of the top five barriers identified by providers, housing and transportation were the two main barriers, each having a greater than 50% response rate of "always or often" hindering a person's access to services. These were followed by client engagement (i.e., readiness for treatment), adequate staffing levels, and child care, all below 50% as "always or often" a barrier. Added to the survey in 2012, **Coordination between Primary Care and Behavioral Health Services** was rated as a moderate barrier (34.6%) by addiction services providers.

Figure 9 below displays the results of the provider survey vs. the qualitative findings from the regions regarding barriers to substance abuse services. Both assessments identified transportation and housing (recovery supports) as pressing barriers to receiving substance use services or maintaining recovery. Navigating services was a significant impediment to obtaining services as also noted in the mental health qualitative assessments. Insurance coverage for appropriate treatment services for those not covered by entitlements or DMHAS services may be addressed within the context of healthcare reform.

Figure 9: Barriers to Substance Abuse Services

Provider Agencies: Top 5 Service Barriers	Always or Often a Barrier		Focus Groups: Top 5 Service Barriers (not in rank order)
Lack of Housing	56.8%		Difficulty Navigating System
Lack of Transportation	51.2%		Lack of Recovery Supports (young Adults)
Lack of Client Engagement	41.9%		Lack of Public Transportation in Rural Areas
Lack of Adequate Staffing	41.0%		Limiting Insurance Options
Lack of Child Care	38.5%		Stigma and Discrimination

Regional Analysis and Variations Substance Abuse Services and Barriers

Those substance abuse clinical services found to have limited availability within each region mirrored the statewide findings. Looking at access to substance abuse services (Figure 10) as has been reported in past need assessments, all levels of residential care were seen as having limited availability. In 2012, the number of regions reporting all levels of residential care as having insufficient availability increased to all five regions with the exception of intensive. Ambulatory detoxification (with and without Buprenorphine) was reported also in more regions in 2012 as having poor availability.

Residential detoxification services were reported as only marginally lacking in availability across four regions, with the exception of the North West Region.

Figure 10: Regional Substance Abuse Clinical Services with Limited Availability

Service Type	Number of Regions Reporting Limited Availability
Long-term Residential	5
Intermediate Residential	5
Intermediate Residential – Pregnant Women	5
Co-occurring Residential	5
Intensive Residential	4
Intensive Outpatient – Pregnant Women	4
Residential Detoxification (medically monitored)	4
Ambulatory Detox - Buprenorphine	4
Chemical Maintenance - Buprenorphine	3
Ambulatory Detox	3
Medically Managed Detox	2
Central Access/Triage Line	2

Recovery supports for persons having a substance use disorder were seen as lacking across most regions for almost all categories (Figure 11). In 2012, both faith based and education services moved from one region reporting limited availability in 2010 to five regions in 2012. Employment services saw a similar jump from one to four regions in the two-year period. Recovery house and sober housing remained basically unchanged and case management changed from two regions to one in 2012.

Figure 11: Regional Substance Abuse Support Services with Limited Availability

Service Type	Number of Regions Reporting Limited Availability
Transportation	5
Education Services	5
Faith Based Services	5
Employment Services	4
Recovery House	4
Sober Housing	4
Case Management	1

For 2012, a number of regions had many fewer barriers that met the threshold of being a hindrance often or always. In fact, one region reported no barriers over 45% as being “often or always” a barrier. The reason for this is unknown. The ratings for those regions reporting no barriers with 50% or greater as “always or often” were essentially the same as in prior years. Housing and transportation (Figure 12) were top rated barriers in three regions followed by insufficient staffing reported by two regions. The remaining barriers, lack of client engagement, long wait lists, childcare, and lack of community supports, had only one region each report them as a significant barrier.

Figure 12: Regional Substance Abuse Service Barriers

Barrier	Number of Regions Reporting Limited Availability
Lack of Transportation	3
Lack of Housing	3
Insufficient Staffing	2
Lack of Client Engagement	1
Long Wait Lists	1
Lack of Child Care	1
Lack of Community Support	1

Recommendations – Substance Abuse Services

The following recommendations on improving the substance use service delivery system address many of the same areas needing attention that were mentioned in the mental health recommendations. Improving access to both clinical and recovery services, including assistance with navigating the public substance use system, is crucial. Assuring that vulnerable populations receive the right care at the right time is extremely important and can lead to better lasting results. Maximizing resources, building strong collaborations and providing training across affected service systems is essential in today's rapidly changing environment.

It is again emphasized that the individual regional priority reports be references as they provide a context in which the following recommendations were developed.

Service System Access & Navigation

- Continue to support and strengthen existing peer navigator/peer supports for clients entering treatment
- Implement a statewide 24-hour access line for substance abuse emergencies that “first responders” (e.g., 211 operators, service agency receptionists) and the general public can use
- Develop a website that contains current information on treatment bed availability for both DMHAS operated and private nonprofit provider agencies
- Replicate the Middlesex Hospital Community Collaborative model, which lowers the incidence of crisis situations through community-based management of high-risk individuals
- Explore and address policies and practices that are barriers to coordinated and effective behavioral health care equity
- Create (and post on DMHAS website) easy to understand flow charts describing points of entry and criteria for accessing and navigating the public substance abuse delivery system
- Place peer mentors in inpatient settings to help individuals understand and navigate the behavioral service system

- Establish priority treatment access points in the community for substance abuse clients presenting at hospital emergency rooms

Service Expansion

- Provide critical services that bridge detox or crisis services and community long-term support for a sustained recovery
- Conduct a comprehensive review of existing residential treatment bed capacity, at all levels, to assess the adequacy based upon current and future demand
- Encourage expansion of medication assisted therapy for opioid addicted persons including the prescribers of Suboxone
- Increase clinical services for people who are deaf/hearing impaired; especially those who do not meet the DMHAS target population criteria

Recovery Supports

- Enhance job readiness by integrating vocational services into clinical services
- Establish a practice improvement collaborative of substance abuse providers to share information on effective employment support practices
- Replicate the “Dry Dock” model which provides a non-threatening and accepting atmosphere allowing persons in recovery and their family members and friends to “normalize” activities (<http://www.thedrydock.org>)
- Expand the availability of recovery coaches and recovery support specialists throughout the system by increased training opportunities
- Promote family involvement in the recovery process
- Integrate and strengthen education services that prepare people for jobs
- Implement a standard of “best practices” for sober houses
- Expand prevention and recovery supports for substance abuse and co-occurring disorders

Young Adults

- Ensure the availability of age-appropriate clinical and recovery services for young adults
- Increase capacity to provide age-appropriate services using evidence based models
- Design or adopt an electronic/virtual system to engage young adults in clinical and recovery support
- Review clinical treatment programs in terms of effective practices regarding individual vs. group counseling
- Educate treatment providers as to the unique clinical and recovery needs of young adults

- Create an interagency coalition that promotes collaboration and improved communication between providers and agencies that work with youth and young adults
- Explore options for providing therapy in natural/comfortable settings for young people

Special Populations

- Recruit and train a selection of treatment providers on geriatric behavioral health care
- Create a Motherhood Program for single moms, modeled after the Fatherhood Initiatives, that addresses not just mothering and parenting skills but also basic life (relationship building, trust, managing finances, etc.) skills
- Expand current resources for substance abuse provider training on Veteran needs and benefits
- Promote cultural competencies through cross-training of staff within hospitals, primary care, psychiatry, senior and adult day care centers, senior housing, home health, protective services and behavioral health services

Other

- Support, through consistent funding, the state's Prescription Monitoring Program (managed by the Department of Consumer Protection) as an effective method of earlier intervention and improved outcomes for opioid addicted persons
- Advocate for uniform practices regarding how professionals prescribe medications through continuing medication education
- Promote drug overdose prevention by expanding educational efforts in the medical community and encouraging primary care providers to conduct brief screening assessments, utilize the Prescription Monitoring Program, and provide drug overdose information to patients and their family (or significant other) members
- Expand pre-release care coordination efforts of inmates released into the community
- Reduce the likelihood of overdoses in the correctional inmate population released to the community by providing pre-release education on the risk of resumption of former drug-taking behavior at levels used prior to incarceration
- Expand drug screenings to include testing for the new intoxicants (e.g., bath salts and synthetic marijuana)

Integrated Care & Wellness

- Promote collaborative relations that support resource sharing between local and regional primary care and wellness organizations and behavioral health providers
- Provide additional resources to implement smoking cessation programs within the addiction service system

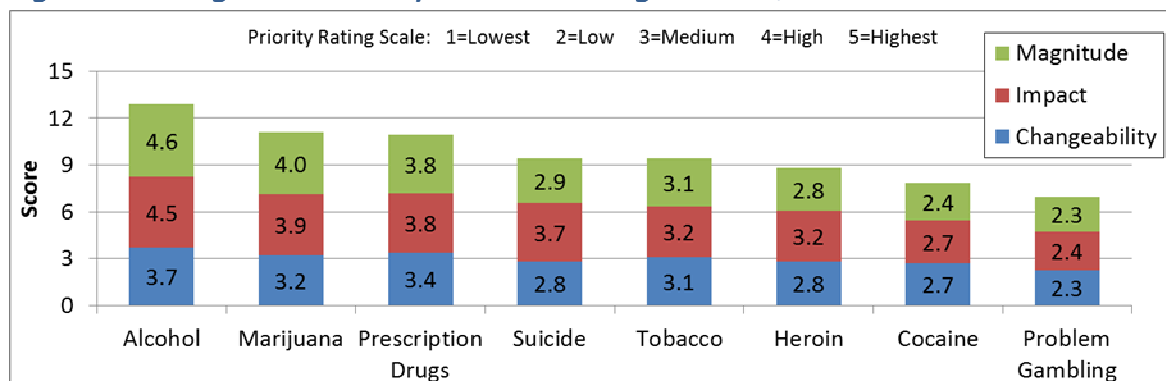
- Encourage the adaptation of Screening, Brief Intervention and Referral to Treatment (SBIRT) in all primary care settings
- Support the co-location of physical and behavioral health services so that clients receive integrated care

Prevention

Since 2006, DMHAS-funded prevention programs have practiced SAMHSA’s Strategic Prevention Framework (SPF) at the state, regional and community levels. The SPF is a 5-step, data-driven process known to promote youth development and prevent problem behaviors across the life span. The steps are: 1) profile needs and response capacity; 2) mobilize and build needed capacity; 3) develop a strategic prevention plan; 4) implement evidence-based programs and strategies; and 5) monitor and evaluate effectiveness.

In 2012, the RACs, using data provided by the State Epidemiologic Outcomes Workgroup (SEOW) along with local data, produced a sub-regional epidemiological profile for 6 substances plus problem gambling and suicide. Each RAC convened a Community Needs Assessment Workgroup (CNAW) to use quantitative and qualitative data to describe and rank each problem with respect to magnitude, impact, and changeability (Figure 13). Taken together, sub-regional CNAWs ranked the 8 areas in the following order: Alcohol, Marijuana, Prescription Drugs, Suicide, Tobacco, Heroin, Cocaine, and Problem Gambling.

Figure 13: Regional Priority Need Ranking Results, 2012



Prevention Priority 1: Alcohol

Prevention of alcohol misuse continued as the top priority across Connecticut. Alcohol use by underage drinkers (12 – 20 year of age) in the previous month varied narrowly across the regions from 29.9% in the Northwest to 33.6% in the East. All regions exceeded the national average of 26.5%. Binge drinking, per the Substance Abuse and Mental Health Services Administration (SAMHSA) is defined as 5 or more drinks on one occasion on at least one day in the past 30 days. Binge drinking was highest among 18 –

25 year olds at 46.8% in Connecticut and 41.0% nationally. The values for binge drinking across Connecticut's regions exceeded the values nationally for all age groups examined. Perceptions of risk associated with binge drinking were generally lower across regions than the national average, but there were exceptions. Specifically, more risk associated with alcohol use was perceived for 12 – 17 year olds in the South West and North Central regions; for 18 – 25 year olds in the South Central region; and for those 18 and older in the South West and North Central regions. There was not a clear correlation between higher perceived risk and less alcohol use in the prior month, however.

Figure 14: Alcohol Use in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Alcohol Use in Past Month (%)							
12 - 17	18.3	20.3	15.7	17.5	18.1	18.2	14.4
18 - 25	*	70.5	*	68.8	66.1	68.2	61.2
12 - 20	30.6	33.3	33.6	30.1	29.9	31.4	26.5
18+	64.7	65.3	60.5	63.6	64.5	64.0	55.7
Binge Alcohol Use in Past Month (%)							
12 - 17	12.3	14.4	10.3	11.4	12.3	12.3	8.6
18 - 25	*	50.0	*	46.3	46.0	46.8	41.0
12 - 20	21.4	24.2	24.1	21.6	21.3	22.4	17.5
18+	28.5	29.9	26.7	27.6	26.4	28.0	25.0
Perceptions of Great Risk of Having 5+ Alcoholic Drinks 1 – 2 times/week							
12 - 17	41.1	38.7	36.8	41.0	37.4	39.4	40.1
18 - 25	32.7	33.7	28.0	31.6	29.2	31.4	33.4
18+	43.8	40.5	36.4	42.6	41.3	41.3	42.3
*low precision; no estimate reported							
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010							

Alcohol-induced deaths across the state rose from 5.1 per 100,000 in 1999 – 2001 per Connecticut Department of Public Health Mortality Statistics to 6.1 per 100,000 in 2007 – 2009. Alcohol-related motor vehicle accidents declined from 7.2 per 10,000 in 2007 per the National Traffic Highway Safety Administration Fatality Analysis Reporting System to 6.6 per 10,000 in 2010. Over the same time period, motor vehicle fatalities decreased from 3.8 to 3.2 per 10,000. School suspensions and expulsions also declined from 12.9 in the 2006/7 school year to 9.3 in the 2010/11 school year based on data from the Connecticut State Department of Education (DOE).

Solutions and Strategies

- Continue the “Set the Rules” media campaign to increase knowledge and awareness of the implications of the Social Host Law
- Collaborate with law enforcement on enforcing underage drinking laws
- Train Pediatricians and Family Physicians on SBIRT (Screening, Brief Intervention and Referral to Treatment)
- Offer server training to employees of alcohol retailers

- Support continued federal funding for Drug-Free Communities (DFC) Support Grants and Sober Truth on Preventing Underage Drinking Act (STOP) Grants for student surveys, school prevention efforts, and evidence-based alcohol retailer compliance checks
- Improve community readiness to collect and report data
- Support Local Prevention Councils (LPC)s implementation of evidence-based strategies

Prevention Priority 2: Marijuana

Marijuana is the most commonly used illicit drug in the United States and the 2008-10 National Survey on Drug Use and Health (NSDUH) reveals the percentage of past year marijuana use by those 12 and older was 13% in Connecticut compared to 11% nationally. Past month Marijuana use also exceeded the national average across regions where data was available.

Figure 15: Marijuana Use in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Marijuana Use in Past Month (%)							
12 - 17	7.6	9.5	8.9	8.4	9.9	8.8	7.2
18 - 25	18.7	23.9	*	23.4	22.3	22.2	17.7
26+	3.8	5.3	6.4	5.0	5.2	5.0	4.6
First Use of Marijuana (%)							
12 - 17	6.0	8.7	5.0	8.1	6.3	7.1	5.8
18 - 25	7.8	9.7	8.0	10.5	10.9	9.4	7.0
26+	*	*	*	*	*	0.2	0.2
Perceptions of Great Risk of Smoking Marijuana once a month (%)							
12 - 17	25.2	25.1	26.0	25.1	28.0	25.9	31.1
18 - 25	18.3	15.5	12.4	16.7	17.0	16.1	20.4
26+	34.2	34.2	*	39.4	38.1	36.0	37.6
*low precision; no estimate reported							
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010							

According to the January 3, 2013 NSDUH Report, “Between 2007 and 2011, the percentage of adolescents who perceived great risk from smoking Marijuana once or twice a week decreased from 54.6% to 44.8%, and the rate of past month Marijuana use among adolescents increased from 6.7% to 7.9%. In 2011, the percentages of adolescents reporting substance use in the past month were generally lower among those who perceived great risk from using substances than among those who did not perceive great risk.”

NSDUH data show that the national decrease in perception of risk from smoking Marijuana 1 – 2 times per week was also true for Connecticut. The percentage of persons ages 12 and older in Connecticut who perceived a great risk of smoking Marijuana

decreased, from 35.8% in 2006-08 to 32.5% in 2008-10. Combined with the increase in the number of people 12 and older using Marijuana in the past year, these indicators may be evidence of greater acceptance of Marijuana use. The decline in perceptions of risk was mirrored across all state regions. The 18 – 25 year olds had the highest percentage of people using Marijuana for the first time, from 7.8% in the South West to 10.9% in the North West. These data do not compare favorably to the national data for this age group, which was 7.0%.

Solutions and Strategies

- Ongoing monitoring of regulations related to medical Marijuana
- Continuing education about harmful effects of Marijuana on brain development as well as raising awareness of drugged driving and Marijuana as a gateway drug
- Organize a grassroots group focused on minimizing the misuse of medical Marijuana
- Ongoing and widespread dissemination of information on myths and facts about Marijuana with a primary focus on the health related risks and clarification of the difference between legalization and decriminalization
- Ensure that Primary Care Physicians are kept updated on trends and research for Marijuana
- Support school police related to Marijuana and other illicit drugs
- Increase intensive affordable residential treatment for teens, especially those under 14
- Continue student surveys to provide information on prevalence, patterns, and consequences of Marijuana use

Prevention Priority 3: Prescription Drugs

Misuse of Prescription Drugs is second only to Marijuana as the nation's most prevalent illicit drug problem. Not surprisingly, 18 – 25 year olds had the highest prevalence of nonmedical use of prescription pain relievers. NSDUH trend data for Connecticut indicates that use peaked in 2006 (5.2%) and declined to a 10-year low in 2009 (3.8%), before rising again in 2011 (4.4%). The 2008-10 NSDUH estimates for Connecticut show that 10.4% of 18 – 25 year olds reported nonmedical use of pain relievers. Regional estimates range from a low of 9.4% in North Central to a high of 11.9% in North West, Connecticut.

At the state level, the rate of pharmaceutical-related school suspensions and expulsions increased dramatically from the 2006/7 school year at 1.59 to 4.56 in the 2009/10 school year, but then dropped back substantially in 2010/11 to 2.03 per 10,000, based on Connecticut State DOE data. This may have been driven by the dramatic increase in suspensions in North Central which rose to 9.98 in 2009/10, then fell back to 1.82 in 2010/11.

Figure 16: Non-Medical Pain Reliever Use in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Nonmedical use of Pain Relievers in Past Year (%)							
12 - 17	4.3	5.2	5.7	4.1	5.8	4.9	6.4
18 - 25	9.6	11.0	10.3	9.4	11.9	10.4	11.7
26+	2.5	2.9	2.8	2.3	2.3	2.7	3.5
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010							

Solutions and Strategies

- More data collection is needed to determine and address persons at risk for Prescription Drug abuse such as the elderly
- Support Medication Take-Back and Medical Drop Box programs on the local, regional, and statewide level to allow community members to safely dispose of Prescription and Over-the-Counter medications and educate the public to the dangers of Prescription Medication abuse
- Increase the number of people who can do small group presentations/discussions on Prescription Drug abuse
- Increase outreach capacity through dissemination of Prescription Drug information to schools, physicians, pharmacies, and realtors
- Increase the number of doctors screening for Prescription Drug abuse
- Implement parent education programs such as the Teen Influencer and PACT 360
- Expand Regional Prevention Committee and Local Prevention Council membership to include treatment professionals based upon a common goal of decreasing the impact of Prescription Medication misuse

Prevention Priority 4: Suicide

Suicide prevention has risen in priority from #5 in the previous 2010 process to #4 for the current report, displacing Tobacco. According to data from the Office of the Chief Medical Examiner, 352 women and 1263 men committed suicide in Connecticut between 2007 and 2011. The majority of these suicides occurred among those ages 30 – 59.

Figure 17: Thoughts of Suicide and Major Depressive Episodes in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Had Serious Thoughts of Suicide in Past Year (%)							
18 - 25	6.11	6.93	6.73	6.01	6.04	6.36	6.47
18+	3.57	4.13	4.44	3.59	3.77	3.85	3.76
26+	3.20	3.68	3.95	3.21	3.43	3.45	3.30
Had at Least One Major Depressive Episode in Past Year (%)							
18 – 25	7.82	7.87	7.96	7.50	8.01	7.79	8.16
18+	5.61	6.16	6.57	5.89	5.79	5.97	6.32
26+	7.82	8.14	8.73	7.64	7.90	8.00	8.24
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010							

Based on the 2008-10 NSDUH data, nearly all Connecticut regions were below the national average with respect to having at least one Major Depressive Episode in the past year, with the exception of the Eastern region for those 18+ and 26+. On the other hand, when the variable is serious thoughts of suicide in the past year, both the Eastern and South Central regions exceeded the Connecticut and national averages for each age category presented.

Solutions and Strategies

- Better integration of early suicide prevention and mental health promotion with overall delivery of prevention services in schools and communities
- Maximize the dissemination of Question, Persuade and Respond (QPR) gatekeeper and CONNECT suicide prevention training and the ONE WORD, ONE VOICE, ONE LIFE campaign
- Suicide as the result of bullying, including cyber bullying, is an area that should receive more resources to effectively intervene when self-injury and attempted suicide occur
- Improve capacity to collect and analyze current, accurate, local data and information about the nature and extent of suicide and self-injury
- Easy access to clinical interventions and support for help-seeking should be increased
- Continue to support anti-bullying programs in schools

Prevention Priority 5: Tobacco

Most Connecticut regions and age groups reviewed were at or below the national average as far as cigarette use in the past month was concerned with the exception of the North West region for 12 – 17 year olds and the North West and North Central regions for 18 - 25 year olds based on the NSDUH. Similarly, use of Tobacco products in the past month, based on NSDUH 2008-10 data, found most of Connecticut below the national average, except for, again the North West region for 12 – 17 year olds and 18 – 25 year olds. The perception of risk data is consistent with these other findings; in that individuals in Connecticut perceive greater risk from smoking at each age group than the national

average. Only in the Eastern region for persons 26+ was the perceived risk estimated as less than that for the nation.

The DMHAS Tobacco Prevention and Enforcement Program supports adherence to laws prohibiting the sale of cigarettes and Tobacco products to minors through compliance inspections. The rate of noncompliance has decreased substantially over the last 10 years. The Connecticut data reported reflects this improved outcome.

Figure 18: Cigarette and Tobacco Use in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Cigarette Use in Past Month (%)							
12 - 17	6.6	8.8	8.8	8.7	9.2	8.4	8.8
18 - 25	35.3	34.1	*	35.9	37.4	35.8	35.5
26+	18.9	20.8	22.9	21.8	20.3	20.9	23.2
Tobacco Product Use in Past Month (%)							
12 - 17	9.3	11.3	10.3	10.5	11.5	10.6	11.3
18 - 25	40.3	40.2	*	41.1	44.0	41.2	41.4
26+	22.0	25.0	26.5	24.7	23.7	24.3	27.7
Perceptions of Great Risk of Smoking 1+ packs of Cigarettes/Day (%)							
12 - 17	71.1	70.0	69.3	69.5	69.7	69.9	66.8
18 - 25	69.0	69.7	64.6	67.8	66.1	67.7	66.2
26+	77.9	76.1	72.9	74.3	76.1	75.6	73.6
*low precision; no estimate reported							
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010							

Connecticut State DOE information reveals decreasing numbers of schools suspensions and expulsions between the 2006/7 school year and the 2010/11 school year from 26% to 21%.

Solutions and Strategies

- Increase smoking cessation initiatives in behavioral health organizations
- Improve access to nicotine replacement therapy
- Promote the use of the American Lung Association program called Teens Against Tobacco Use (TATU) in which high school teens are trained to do one-class presentations to elementary or middle school aged children
- Increase the number of designated bilingual staff persons to work with small retail stores
- Improve knowledge of Medicaid billing practices for smoking cessation supports
- Increase dissemination of free smoking cessation curriculum, called learning About Healthy Living to clinicians
- Support the continuation of the Statewide Tobacco Education Program (STEP)

Prevention Priority 6 & 7: Heroin and Cocaine

Little data is available specific to Heroin and Cocaine. On national surveys they are both included under “Illicit Drugs”, but state and regional level data is limited. The 2008-10 NSDUH estimates that in Connecticut, 3.56% of those 12+ (127,238 persons) used illicit drugs other than Marijuana during the past year. More concerning is the apparent trend for those 18 and older to continue to use illicit drugs at rates at or above the national average, particularly in South Central and North West regions.

Available data on Cocaine usage in the past year reveals Connecticut averages slightly exceed the national average for those 12 – 25, and then falls slightly below for those 26+.

Figure 19: Illicit Drug and Cocaine Use in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Past Month Illicit Drug use Other than Marijuana (%)							
12 - 17	4.3	4.6	4.4	4.1	4.8	4.4	4.5
18 - 25	7.9	8.5	8.0	7.9	9.4	8.3	8.0
26+	2.7	3.0	2.4	2.4	3.7	2.8	2.7
Past year Cocaine Use (%)							
12 - 17	*	1.1	1.4	1.2	1.1	1.2	1.1
18 - 25	4.6	5.0	5.9	6.0	4.6	5.3	5.2
26+	1.3	1.2	1.5	1.5	1.3	1.4	1.5
Illicit Drug Dependence in Past Year (%)							
12 - 17	2.3	2.4	2.4	2.5	3.2	2.6	2.5
18 - 25	5.6	6.6	5.0	5.5	6.2	5.8	5.5
26+	1.1	1.4	1.2	1.3	1.5	1.3	1.2
*low precision; no estimate reported							
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010							

Regions demonstrating highest prevalence of past year Cocaine use per NSDUH data, are the Eastern and North Central regions.

Connecticut exceeds national averages across age groups for the category Illicit Drug Dependence in the Past Year. This concerning result is most obvious for the 18 – 25 year old group which meets or exceeds the national average in each region except the East, and likewise for those 26+ in all regions except the South West. The younger age group (12 – 17) matches the 2.5% national average and only exceeds in the North West region.

Illicit drug-related school suspensions and expulsions rose between the 2006/7 school year and the 2010/11 school year across Connecticut from 20.6 to 24.1 per 10,000.

Solutions and Strategies

- Increase collection of local data and information about the incidence of Heroin and Cocaine use to inform future prevention activities

- Focus prevention activities on raising awareness and building partnerships as most people seem unaware of or in denial of the existence of illicit drug use in general, and Heroin and Cocaine use, in particular
- Maintain efforts in the areas of education, law enforcement, and treatment capacity for dealing with Heroin and Cocaine

Prevention Priority 8: Problem Gambling

The vast majority of individuals in Connecticut who gamble are able to do so with little or no adverse consequences. The prevalence of Problem Gambling is correlated to population and access to gambling opportunities. Gambling disorders are significantly more prevalent among males and younger persons than the general population.

According to the Connecticut Council on Problem Gambling's 2010 Annual Helpline Report, just over 300 problem gamblers called their helpline. Most were male (64.8%) and white (76.5%) and in their forties. The most recent study of youth gambling in Connecticut, from 2008, found that 90% of students surveyed reported having gambled in the past year and about 32% of students first gambled at age 11 or younger. Of those surveyed, 10.4% were classified as probable problem gamblers.

Solutions and Strategies

- Continue to deliver Gambling-Informed prevention services to the area and especially to at-risk populations such as college students and the elderly
- Hold quarterly regional meetings for providers implementing gambling prevention and treatment services
- Continue to disseminate the Taking Charge: A Path to Healthy Choices curriculum to address risk behaviors, problem solving, risk reduction, and healthy decision-making for middle and high school aged youth
- Sustain the Connecticut Women and Problem Gambling Project and the Congregation Assistance Program (CAP) for clergy and laypersons
- Sustain the Bettor Choice outpatient program for problem gamblers
- Improve data collection to measure changes in prevalence and to better understand the impact of problem gambling on Connecticut's communities
- Improve outreach to those already struggling financially who may be at a higher risk for problem gambling and to a broader range of cultural groups

Appendix A

Statewide Regional Provider Survey Results

**Mental Health Services
With and Without “Don’t Knows (DKs)”**

Clinical Availability (with DKs)			
Service Type	Not/Sometimes	Often/Always	Don’t Know
MH Acute IP DMHAS	67.4%	18.9%	13.7%
MH Co-occurring IP	60.2%	31.6%	8.2%
SubAcute	58.8%	16.5%	24.7%
YAS IP	57.1%	13.3%	29.6%
Respite	53.6%	23.7%	22.7%
ACT	44.3%	24.7%	30.9%
MH Acute IP – Gen. Hosp.	39.6%	51.0%	9.4%
OP Psychiatrist/APRN	35.4%	56.3%	8.3%
YAS Community Teams	34.7%	26.5%	38.8%
MH Crisis	32.7%	58.2%	9.2%
Jail Diversion	31.6%	46.9%	21.4%
Intensive Outpatient	30.6%	63.3%	6.1%
MH Co-occurring OP	27.6%	65.3%	7.1%
MH Outpatient	19.4%	77.6%	3.1%

Clinical Availability (without DKs)		
Service Type	Not/Sometimes	Often/Always
YAS IP	81.2%	18.8%
SubAcute	78.1%	21.9%
MH Acute IP DMHAS	78.0%	22.0%
Respite	69.3%	30.7%
MH Co-occurring IP	65.6%	34.4%
ACT	64.2%	35.8%
YAS Community Teams	56.7%	43.3%
MH Acute IP – Gen. Hosp.	43.7%	56.3%
Jail Diversion	40.3%	59.7%
OP Psychiatrist/APRN	38.6%	61.4%
MH Crisis	36.0%	64.0%
Intensive Outpatient	32.6%	67.4%
MH Co-occurring OP	29.7%	70.3%
MH Outpatient	20.0%	80.0%

Recovery Availability (with DKs)			
Service Type	Not/Sometimes	Often/Always	Don't Know
Transportation	66.3%	27.6%	6.1%
Group Homes	62.2%	22.4%	15.3%
Supervised Apartments	59.2%	31.6%	9.2%
Supportive Housing	58.3%	34.4%	7.3%
Supported Education	52.0%	36.7%	11.2%
Peer Support	35.7%	54.1%	10.2%
Supported Employment	35.1%	57.7%	7.2%
Outreach & Engagement	33.0%	61.9%	5.2%
CSP/RP	33.0%	48.5%	18.6%
Psychosocial Rehab	22.7%	66.0%	11.3%

Recovery Availability (without DKs)		
Service Type	Not/Sometimes	Often/Always
Group Homes	73.5%	26.5%
Transportation	70.7%	29.3%
Supervised Apartments	65.2%	34.8%
Supportive Housing	62.9%	37.1%
Supported Education	58.6%	41.4%
CSP/RP	40.5%	59.5%
Peer Support	39.8%	60.2%
Supported Employment	37.8%	62.2%
Outreach & Engagement	34.8%	65.2%
Psychosocial Rehab	25.6%	74.4%

Barriers to Treatment (with DKs)			
Service Type	Not/Sometimes	Often/Always	Don't Know
Housing	33.9%	63.9%	3.1%
Transportation	40.8%	58.2%	1.0%
Staffing	52.0%	45.9%	2.0%
Coordination between Primary Care & BH Care	56.1%	42.9%	1.0%
Long Waiting List	60.2%	39.8%	0.0%
Child Care	46.3%	36.8%	16.8%
Workforce Development	61.2%	35.7%	3.1%
Length of Stay Limitations	59.6%	35.4%	5.1%
Payment Requirements	62.2%	33.7%	4.1%
Public Awareness	69.4%	28.6%	2.0%
Client Engagement	72.7%	27.3%	0.0%
Coord. SA/MH Providers	73.5%	24.5%	2.0%
Community Supports	71.4%	24.5%	4.1%
Eligibility Criteria	74.7%	22.2%	3.0%
Medication Side Effects	73.5%	20.4%	6.1%
Coordination Human Services	78.6%	19.4%	2.0%
Language	80.4%	15.5%	4.1%
Hours of Operation	86.6%	13.4%	0.0%

Barriers to Treatment (without DKs)		
Service Type	Not/Sometimes	Often/Always
Housing	34.0%	66.0%
Transportation	41.2%	58.8%
Staffing	53.1%	46.9%
Child Care	55.7%	44.3%
Coordination between Primary Care & BH Care	56.7%	43.3%
Long Waiting List	60.2%	39.8%
Workforce Development	63.2%	36.8%
Length of Stay Limitations	62.8%	37.2%
Payment Requirements	64.9%	35.1%
Public Awareness	70.8%	29.2%
Client Engagement	72.7%	27.3%
Community Supports	73.5%	24.5%
Coord. SA/MH Providers	75.0%	25.0%
Eligibility Criteria	77.1%	22.9%
Medication Side Effects	78.3%	21.7%
Coordination Human Services	80.2%	19.8%
Language	83.9%	16.1%
Hours of Operation	86.6%	13.4%

Addiction Services
With and Without “Don’t Knows (DKs)”

Clinical Availability (with DKs)			
Service Type	Not/Sometimes	Often/Always	Don’t Know
Long Term Care	70.7%	10.9%	18.5%
Intermediate Residential	68.1%	17.0%	14.9%
Intensive Residential	60.2%	25.8%	14.0%
Intermediate Resid. Women	60.2%	14.0%	25.8%
Co-occurring Residential	58.1%	25.8%	16.1%
Residential (Medically Monitored) Detoxification	46.8%	33.0%	20.2%
Ambulatory Buprenorphine	46.8%	24.5%	28.7%
Medically Managed Detox	45.7%	37.2%	17.0%
Ambulatory Detox	43.6%	27.7%	28.7%
Chemical Maintenance Bup	38.5%	35.2%	26.4%
Intensive OP Pregnant Women	38.3%	26.6%	35.1%
Intensive Outpatient	33.0%	54.3%	12.8%
Screening/Brief Intervention	30.9%	55.3%	13.8%
Co-occurring Outpatient	29.8%	59.6%	10.6%
Access Lines	28.7%	47.9%	23.4%
Methadone Maintenance	23.7%	62.4%	14.0%
Assessment	22.3%	60.6%	17.0%
Standard Outpatient	19.1%	70.2%	10.6%

Clinical Availability (without DKs)		
Service Type	Not/Sometimes	Often/Always
Long Term Care	86.7%	13.3%
Intermediate Resid. Women	81.2%	18.8%
Intermediate Residential	80.0%	20.0%
Intensive Residential	70.0%	30.0%
Co-occurring Residential	69.2%	30.8%
Ambulatory Buprenorphine	65.7%	34.3%
Ambulatory Detox	61.2%	38.8%
Intensive OP Pregnant Women	59.0%	41.0%
Residential (Medically Monitored) Detoxification	58.7%	41.3%
Medically Managed Detox	55.1%	44.9%
Chemical Maintenance Bup	52.2%	47.8%
Intensive Outpatient	37.8%	62.2%
Access Lines	37.5%	62.5%
Screening/Brief Intervention	35.8%	64.2%
Co-occurring Outpatient	33.3%	66.7%
Methadone Maintenance	27.5%	72.5%
Assessment	26.9%	73.1%
Standard Outpatient	21.4%	78.6%

Recovery Availability (with DKs)			
Service Type	Not/Sometimes	Often/Always	Don't Know
Transportation	66.3%	21.1%	12.6%
Education	57.9%	25.3%	16.8%
Employment	52.6%	33.7%	13.7%
Sober House	51.6%	33.7%	14.7%
Faith Based	51.6%	21.1%	27.4%
Recovery House	48.4%	35.8%	15.8%
Case Management	41.1%	44.2%	14.7%

Recovery Availability (without DKs)		
Service Type	Not/Sometimes	Often/Always
Transportation	75.9%	24.1%
Faith Based	71.0%	29.0%
Education	69.6%	30.4%
Employment	61.0%	39.0%
Sober House	60.5%	39.5%
Recovery House	57.5%	42.5%
Case Management	48.1%	51.9%

Barriers to Treatment (with DKs)			
Service Type	Not/Sometimes	Often/Always	Don't Know
Housing	36.8%	48.4%	14.7%
Transportation	42.1%	44.2%	13.7%
Client Engagement	52.6%	37.9%	9.5%
Staffing	48.4%	33.7%	17.9%
Long Waiting List	54.3%	31.9%	13.8%
Length of Stay Limitations	54.3%	30.9%	14.9%
Coordination between Primary Care & BH Care	56.0%	29.7%	14.3%
Community Supports	55.8%	28.4%	15.8%
Eligibility Criteria	58.9%	28.4%	12.6%
Child Care	42.6%	26.6%	30.9%
Payment Requirements	60.0%	25.3%	14.7%
Public Awareness	66.3%	25.3%	8.4%
Workforce Development	53.7%	25.3%	21.1%
Coordination Human Services	67.4%	21.1%	11.6%
Coord. SA/MH Providers	70.5%	20.0%	9.5%
Language	70.5%	15.8%	13.7%
Hours of Operation	74.7%	11.6%	13.7%
Medication Side Effects	71.6%	11.6%	16.8%

Barriers to Treatment (without DKs)		
Service Type	Not/Sometimes	Often/Always
Housing	43.2%	56.8%
Transportation	48.8%	51.2%
Client Engagement	58.1%	41.9%
Staffing	59.0%	41.0%
Child Care	61.5%	38.5%
Long Waiting List	63.0%	37.0%
Length of Stay Limitations	63.8%	36.3%
Coordination between Primary Care & BH Care	65.4%	34.6%
Community Supports	66.3%	33.8%
Eligibility Criteria	67.5%	32.5%
Workforce Development	68.0%	32.0%
Payment Requirements	70.4%	29.6%
Public Awareness	72.4%	27.6%
Coordination Human Services	76.2%	23.8%
Coord. SA/MH Providers	77.9%	22.1%
Language	81.7%	18.3%
Medication Side Effects	86.1%	13.9%
Hours of Operation	86.6%	13.4%